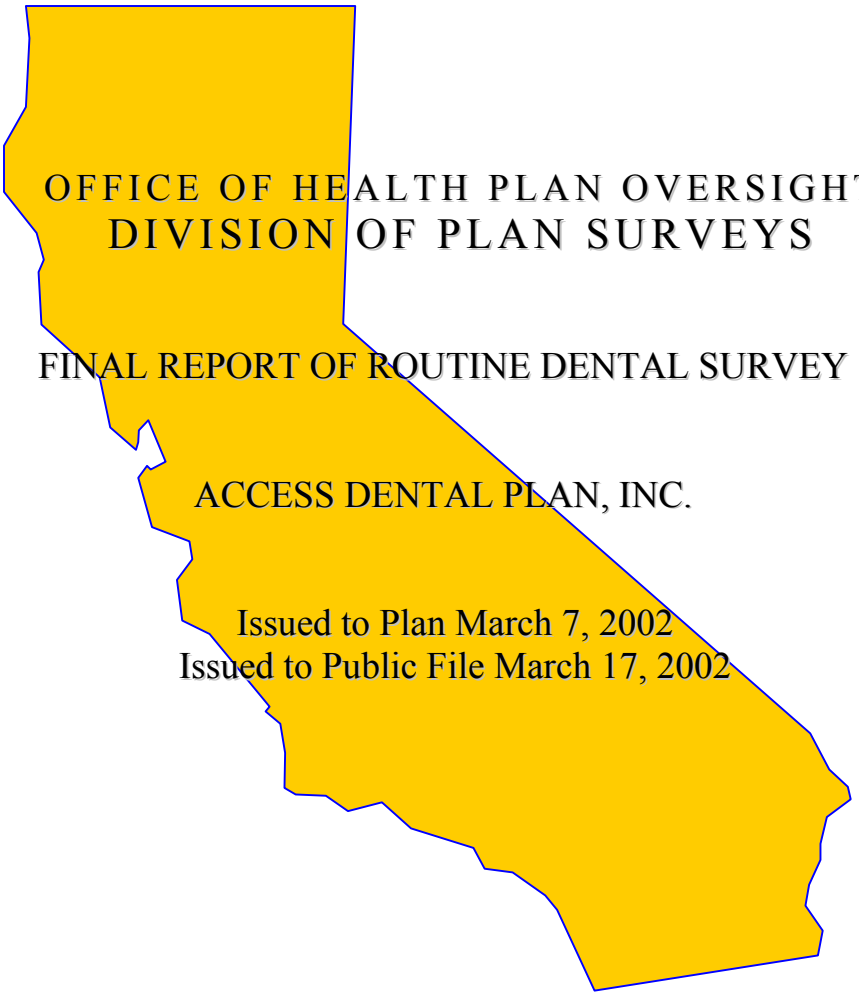
STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE



OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

FINAL REPORT OF ROUTINE DENTAL SURVEY

ACCESS DENTAL PLAN, INC.

Issued to Plan March 7, 2002
Issued to Public File March 17, 2002

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I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department"), formerly the Department of Corporations, to conduct a dental survey of each licensed health care service plan ("Plan") at least once every three (3) years. The dental survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1380.80.[1] Generally, the subjects of the survey fall into the following categories:

- Quality Assurance Program
- Accessibility of Services
- Utilization Management
- Grievance System

Access Dental Plan, Inc. (the "Plan") submitted pre-survey documents to the Department on July 2, 2001. The Department conducted the on-site review of the Plan on September 5-7, 10-14, and September 26, 2001. The Preliminary Report of the survey findings was sent to the Plan on November 19, 2001.

All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report and submitted a response on January 4, 2002.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department. If the Plan wishes to append its response to the Preliminary Report to the Final Report please notify the Department before March 15, 2002.

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California after March 17, 2002. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report. In the event the Plan wishes to append a brief statement to the summary report, as set forth in Section 1380(h)(5), please send it to the Department before March 15, 2002.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. Final Reports are also available on the Department's web-site: www.dmhc.ca.gov.

[1] References throughout this report to "Section ___" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as Amended [California Health and Safety Code Section 1340 *et seq*. ("the Act") References to "Rule ___" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43 and transferred to the Department of Managed Health Care pursuant to Health and Safety Code section 1341.14 ("the Rules")].

The Plan may file an addendum to its response at anytime after the Final Report is issued to the public. Copies of the addendum are also available from the Department at cost. Persons wanting copies of an addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan and will issue a follow-up report within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Finally, Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the dental survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

Scope of Survey

At the Plan's administrative offices, the Department reviewed: twenty-nine (29) grievances filed at the Plan or with the Department; the Plan's grievance and appeal procedures; information from the Plan's quality assurance system, including minutes of the committees responsible for Plan quality management activities; provider credentialing files; specialty referral requests; and Plan information for providers describing Plan policies and benefits. The Department also conducted interviews with staff responsible for these areas.

The Department also reviewed charts of enrollees who had received general dental care at three of the Plan's participating general dental offices; and charts of enrollees who had received orthodontic services at two of the Plan's participating orthodontic offices. The Department reviewed a total of 40 patient charts for the three general practice offices, and 14 patient charts for the two orthodontic offices. Further, the Department reviewed grievances that had been filed in the three general dental offices.

II. OVERVIEW OF ORGANIZATION

The following additional background information describes the Plan:

Date Plan Licensed	December 22, 1993
Type of Plan	Specialized Dental Plan
Provider Network	The Plan has contracting general and specialty dental providers throughout northern and southern California. The Plan's dental provider network, which is comprised of 1,895 general dentists and 53 orthodontists as of June 30, 2001. Other dental specialists include oral surgeons, periodontists, endodontists, and pedodontists.
Plan Enrollment	As of July 1, 2001, the Plan had total Medi-Cal Program enrollment of 123,433. All of these enrollees are associated with Geographic Managed Care ("GMC"), Los Angeles Prepaid Health Program ("LAPHP"), and the Healthy Families Program ("HFP"). Please note that orthodontia is not a covered benefit in the Healthy Families Program. It is only a covered benefit in the GMC (Sacramento County) and LAPHP (Los Angeles County) Medi-Cal programs.

Current Service Area And Enrollment By County

COUNTY	*Enrollment*	COUNTY	*Enrollment*	COUNTY	*Enrollment*
Alameda	*639*	**Riverside**	*4,350*	**Shasta**	*0*
Butte	*0*	**Sacramento**	*56,985*	**Solano**	*581*
Contra Costa	*673*	**San Bernardino**	*3,712*	**Stanislaus**	*1,809*
Fresno	*1,881*	**San Diego**	*5,655*	**Sutter**	*0*
Kern	*848*	**San Francisco**	*66*	**Tulare**	*0*
Los Angeles	*29,729*	**San Joaquin**	*1,348*	**Ventura**	*2,828*
Madera	*0*	**San Mateo**	*60*	**Yolo**	*0*
Merced	*625*	**Santa Clara**	*647*	**Yuba**	*0*
Orange	*10,997*	**Santa Cruz**	*0*		

Provider Mix

Staff Model		Contracted (Independent) Providers
Providers	**Offices**	
38	15	1,857

Provider Compensation	General dentists are compensated either on a fee for service basis or based on a mixed model of capitation and fee for service for certain preventive and major services. In addition, many capitated providers are paid $5.00 for each unduplicated encounter. All the specialist providers are compensated on a fee for service basis.

III. SUMMARY OF DEFICIENCIES IDENTIFIED IN THE DENTAL SURVEY

The Department of Managed Health Care survey of Access Dental Plan (the "Plan") has found the following deficiencies that the Plan is required to correct:

QUALITY ASSURANCE PROGRAM

Deficiency 1: **The Plan's quality assurance program did not demonstrate that the quality of care provided is being reviewed, that problems are being identified, and effective action is taken to improve care whether deficiencies are identified at general dental offices.** [Section 1370, Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A) and (B)]

Deficiency 2: **The Plan's QA program did not provide appropriate documentation that the quality of care provided is being reviewed, that problems are being identified, and effective action is taken to improve care were deficiencies are identified at orthodontic offices.** [Section 1370, Rule 1300.70(a)(1) and (b)(1)(A) and (B)]

ACCESSIBILITY OF SERVICES

Deficiency 3: **The Plan did not demonstrate a mechanism in place to assure reasonable access for dental care.** [Section 1367(e)(1), Rule 1300.67.2(d)]

UTILIZATION MANAGEMENT

Deficiency 4: **The Plan did not demonstrate a consistent mechanism in place to ensure that the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, treatment authorization requests in a timely manner to meet the requirements of the Act.** [Section 1367.01(a) and (b) and 1367.01(h)(1)(2) and (3)]

GRIEVANCE SYSTEM

Deficiency 5: **The Plan's grievance system does not identify, adequately follow-up, and resolve quality of care issues contained within enrollee grievances.** [Section 1368(a)(1) and Section 1370, Rule 1300.68(b)(1) and Rule 1300.70(b)(1)(A) and (B)]

IV. PLAN'S EFFORTS TO CORRECT DEFICIENCIES

Upon reviewing the Plan's response to the Preliminary Report, the Department found that the Plan had fully corrected the following deficiency:

- Utilization Management: Deficiency 4

For all other Deficiencies cited, the Department found in some cases that although the Plan had initiated corrective actions, full implementation of those actions, and assessment of the effectiveness, will require more then forty-five (45) days. The deficiencies that remain uncorrected are as follows:

- Quality Assurance Program: Deficiency 1, 2*
- Accessibility of Services: Deficiency 3
- Grievance System: Deficiency 5*

Please note that for **Deficiency 2, the Plan is required to submit clarification based on their response to the Preliminary Report within 30 days upon receiving the Final Report. For **Deficiency 5**, the Plan is required to submit additional information to the Department within 30 days upon receiving the Final Report.*

At the time of the Follow-up Review, the Department will review the Plan's activities to assess the efficacy of the corrective action plans in remedying issues of non-compliance.

V. DISCUSSION OF DEFICIENCIES AND CORRECTIVE ACTIONS

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's quality assurance program did not demonstrate that the quality of care provided is being reviewed, that problems are being identified, and effective action is taken to improve care whether deficiencies are identified at general dental offices. [Section 1370, Rule 1300.70(a)(1) and Rule 1300.70(b)(1)(A) and (B)]

Citation: Section 1370
Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

Citation: Rule 1300.70(a)(1)
The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are identified, and that follow up is planned where indicated.

Citation: Rule 1300.70(b)(1)
(A) A level of care which meets professionally recognized standards of practice is being delivered to all enrollees.

(B) Quality of care problems are identified and corrected for all provider entities.

Discussion: The Department's review of three general practices (two contracted and one staff model practice) found that the Plan failed to detect instances in which quality of care delivered by general dental providers failed to meet professionally recognized standards of care. The Plan's audits of its general dental practices failed to include a sample of records that would permit a comprehensive assessment of the quality of care provided to enrollees.

The Plan's method to select patient records for its audits of general dental practices was described by the Plan as one in which the Plan auditor calls the practice and requests that it select twenty (20) records over the last ten (10) months. Ten months is used since the previous audit was twelve (12) months ago and two months are given for the practice to make modifications to correct deficiencies identified at that audit. The auditor asks for both new and established patients, including some with cases involving root canals. From these twenty (20) cases, the auditor picks ten (10), usually excluding any that do not have x-rays.

The Department found that the method of chart selection is deficient in two ways. First, the Plan allows the practice to determine the sample of records that will be audited. Giving the practice the opportunity to determine which records are used could allow problematic cases to be excluded.

Second, the method did not consistently produce a sample of patient records with an adequate range of dental diagnosis and treatments. As a result, the Plan would have a difficult time assuring the quality of care being provided to enrollees, including an evaluation of outcome of care.

The Department also found that the Plan's "Dental Clinical Records Quality Assessment" form provides for an evaluation of the quality of treatment include the following: **1)** quality of fillings (using post-treatment x-rays); **2)** periodontal treatment including appropriateness of treatment and calculus removal (using post-treatment x-rays); **3)** root canal treatment; and **4)** crowns and bridges.

These are all basic services provided in general dental practices. However, based in the concerns raised on the method of chart selection, the Department found the Plan's March 2000 audit lacked certain aspects of the evaluation of three practices.

Additionally, the Department found deficiencies in reviewing the same charts as the Plan audits and involves the quality of care in the practices that were not identified by the Plan. The areas reviewed by the Department included: Informed Consent[1], X-rays, Preventive Care, and Treatment Planning.

The Department also found that deficiencies in quality identified by the Plan in its audits of general dental practices were either not corrected in subsequent audits or were not evaluated.

1) In the first practice (a contracted practice) reviewed by the Department the Plan conducted two audits of this practice. Of the deficiencies found on the first audit, there were four that persisted at the Plan's second audit.

[1] *Please note that the Department's observation related to "Informed Consent" was provided to the Plan as a finding since it is not specifically defined by the Act as a requirement.*

These deficiencies include the lack of sufficient x-rays for diagnosis. Though identified in the first audit, eight of 10 cases (or 80%) in the second audit did not meet recognized standards. X-rays are a critical element in dental care because many pathological conditions cannot be detected without them. Without appropriate x-rays, both the diagnosis and the treatment plan that would follow from the diagnosis could be compromised. Another significant aspect of care where quality problems persisted was diagnosis of the need for sealants to prevent decay.

In addition, there were two other areas where deficiencies found in the first audit were not evaluated in the second audit. This included documentation of consultation with a physician when appropriate and diagnosis of space maintainers. These conditions occur infrequently, but given that both could lead to significant problems, there should have been evidence that the Plan had sought to identify charts that would permit as assessment of these aspects of care.

2) In the second practice (also a contracted practice) there were aspects of care that were either not corrected in a timely manner or not evaluated by the Plan when the practice was re-audited. The four most recent audits conducted by the Plan were in October 1998, November 1999, February and May 2001.

The last audit was conducted because the previous one had a score of less than 80% in the "Management of Patient Care" section which required that the practice be placed on probation and audited two months following the practice being notified of the findings in April, 2001.

The practice did not revise its medical history to include questions on pacemaker and joint replacement after the deficiency was found in November, 1999 and the Plan did not include an evaluation of the medical history on its final audit. These questions are essential to be included in a medical history since they can significantly alter the methods used to diagnose and treat dental disease.

On two of the three audits for this practice, the Plan found that there was a failure to update the medical history. In the February 2001, audit, two of the three applicable cases did not have the medical history updated. This aspect of care was not evaluated in the May 2001 audit. The February, 2001 audit found a deficiency in the diagnosis of decay. The follow-up audit in May 2001 found that diagnosis of decay was not acceptable in two of 10 cases (or 20%). The practice passed the review and was taken off of probation. The letter to the practice following this audit made no mention of the need for improvement in the diagnosis of decay.

Corrective Action 1: The Plan shall submit a corrective action plan (CAP) that demonstrates a timely process/mechanism to continuously review the quality of care, provide and ensure that quality of care issues are identified and corrected for provider entities. The Plan shall submit copies of revised policies and procedures accordingly.

In addition, the Plan shall submit the appropriate policy and procedure, which is to be followed by the Plan to correct unacceptable findings as a result of the Plan audits. The description shall

include, but not be limited to, the timetable for provider corrective actions, the sanctions to be imposed for non compliance, and the timetable for sanctions.

Plan's Compliance Effort: The Plan stated that it has revised the general practice chart audit selection criteria. In preparation for the audits, the Plan's auditor will provide the dental provider's office with a list of enrollees who were selected using the Plan's encounter data. The selection of these charts will include a wide range of dental procedures including basic and/or major services. The auditor will review at minimum ten (10) charts for the audit.

The Plan stated that it has also revised the policies and procedures to correct unacceptable findings as a result of the Plan audits. In the event that the provider scores less than 80%, the Dental Director will place that provider on probation and will not be assigned any new patients. The provider will have 60 days to correct the deficiencies. If the provider's deficiency is a confirmed quality issue deficiency that could jeopardize an enrollee's health, then the provider will be placed on probation by the Dental Director and must immediately correct the deficiency within 48 hours of identification. In the event that the provider does not show improvement or is uncooperative with the Plan's improvement efforts, the Dental Director will consult with the Quality Improvement Committee ("QIC") to determine the next appropriate corrective action, up to and including termination of the provider's contract. The provider will remain on probation pending the QIC's decision or recommendations. The recommendations may include further investigation through a focused review or studies, education to the provider, or disciplinary actions.

The Plan stated that it is currently implementing the corrective action plan outlined above. The Quality Improvement Committee has revised and approved these policies on December 19, 2001. The Plan submitted as evidence a redlined version of the revised policies and procedures title "Dental Chart Audits" *(Procedure #: QIP-013).*

Department's Finding Concerning Plan's Compliance Effort:

Status: Uncorrected

The Plan has taken appropriate steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department's review of the revised Dental Chart Audits policy [identified as "Exhibit A" in the Plan's Response] does indicate that the Plan has a process/mechanism for ensuring quality of care issues are identified and the handling of unacceptable findings. In addition, is the proposed timetable for provider corrective actions and sanctions for non-compliance.*

However, as stated at the beginning of this section, though the efforts appear to be in place the Plan did not demonstrate the effectiveness of the revised policy and procedure by the date of the Plan's Response. At the time the Department conducts a Follow-up Review of the Plan the Department will make the determination whether the deficiency has been fully corrected.

Deficiency 2: **The Plan's QA program did not provide appropriate documentation that the quality of care provided is being reviewed, that problems are being identified, and effective action is taken to improve care were deficiencies are identified at orthodontic offices.** [Section 1370, Rule 1300.70(a)(1) and (b)(1)(A) and (B)]

Citation: Rule 1370 as stated above.

Citation: Rule 1300.70(a)(1)
The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are identified, and that follow up is planned where indicated.

Citation: Rule 1300.70(b)(1)
(A) A level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) Quality of care problems are identified and corrected for all provider entities;

Discussion: The Plan's quality assurance program did not ensure the consistent identification of quality of care issues at the Plan's orthodontic offices. The Department selected two orthodontic practices for chart review. The Plan audited ten patient charts from the first orthodontic practice on March 16, 2001. All ten patient charts were available for the Department's review. The Plan audited ten patient charts from the second orthodontic practice on May 9, 2000. Four of those patient charts were available for the Department's review. Although the Department's review found deficiencies related to quality of care being provided by these two practices, the Plan did not detect any problems.

Corrective Action 2: The Plan shall submit a CAP that demonstrates a timely process/mechanism to continuously review the quality of care, provide and ensure that quality of care issues are identified and corrected for provider entities. The Plan shall submit copies of revised policies and procedures accordingly.

In addition, the Plan shall submit the appropriate policy and procedure, which is to be followed by the Plan to correct unacceptable findings as a result of the Plan audits. The description shall include, but not be limited to, the timetable for provider corrective actions, the sanctions to be imposed for non compliance, and the timetable for sanctions.

Plan's Compliance Effort: The Plan stated that it has revised the orthodontic practice chart audit selection criteria. A review audit will consist of a thorough review of each facility and not less than ten (10) patient charts per orthodontic provider at each dental office. The treating orthodontist provider will not participate in the selection of the charts. The ten charts audited will be selected from a requested group of twenty patient records. The orthodontic auditor will select seven cases in treatment and three finished cases. Representative groups of patients in treatment for 1-6 months, 6-18 months, and 18-24 months will be chosen. The finished cases will consist of patients whose treatment was finished within a period of six months prior to the audit. The auditor will review only the Plan's charts and the charts will be identified by patient name. The Plan states that it does not intend to use a patient identifying number as the identifying number is not an orthodontic criteria and is not the standard of care in the industry. The Plan stated that if the orthodontic provider has less than ten Plan patients, then auditor will then review all the Plan's charts at the practice.

In addition, the Plan stated that it revised the policies and procedures to correct unacceptable findings as a result of the Plan audits. In the event that the orthodontic provider scores less than 70%, the Dental Director will place that provider on probation and will not be assigned any new patients. The orthodontic provider will have 60 days to correct the deficiencies. If the orthodontic provider's deficiency is a confirmed quality issue deficiency that could jeopardize an enrollee's

health, then the provider will be placed on probation by the Dental Director and must immediately correct the deficiency within 48 hours of identification. In the event that the provider does not show improvement or is uncooperative with the Plan's improvement efforts, the Dental Director will consult with the Quality Improvement Committee ("QIC") to determine the next appropriate corrective action, up to and including termination of the provider's contract. The provider will remain on probation pending the QIC's decision or recommendations. The recommendations may include further investigation through a focused review or studies, education to the provider, or disciplinary actions.

The Plan stated that it has implemented the corrective action plan outlined above. The Quality Improvement Committee revised and approved these policies on December 19, 2001. The Plan submitted as evidence a redlined version of the revised policies and procedures on Orthodontic Records Review titled "Standards and Methodology For Orthodontic Review" *(Procedure #: QIP-038).*

Department's Finding Concerning Plan's Compliance Effort:

Status: Uncorrected

The Plan has taken appropriate steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department's review of the revised Standards and Methodology For Orthodontic Review policy [identified as "Exhibit B" in the Plan's Response] does indicate that the Plan has a process/mechanism for ensuring orthodontic quality of care issues are identified and the handling of unacceptable findings. In addition, is the proposed timetable for provider corrective actions and sanctions for non-compliance.*

However, as stated at the beginning of this section, though the efforts appear to be in place the Plan did not demonstrate the effectiveness of the revised policy and procedure by the date of the Plan's Response. At the time the Department conducts a Follow-up Review of the Plan the Department will make the determination whether the deficiency has been fully corrected.

Requested Clarification: In addition, the Department is requesting that the Plan provide clarification as to the reason why the scoring criteria for placing an orthodontic provider on probation are a score of less than 70%. The corresponding policy for general dentists sets the scoring criteria at less than 80%. The Plan shall submit the clarification within thirty (30) days of the date that the Plan receives the Final Report.

ACCESSIBILITY OF SERVICES

Deficiency 3: The Plan did not demonstrate a mechanism in place to assure reasonable access for dental care. [Section 1367(e)(1), Rule 1300.67.2(d)]

Citation: Section 1367(e)(1)
All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

Citation: Rule 1300.67.2(d)
The ratio of enrollee to staff, including health professional, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.

Discussion: The Department found that the Plan's standard states that appointments for initial exams and/or non-emergency routine services must be made within three weeks of the date a enrollee requests an appointment, "based on availability." In addition, the Plan's standard for in-office wait time is no more than 30 minutes for both regularly scheduled non-emergency patients and scheduled emergency patients (patients calling the practice complaining of pain and requesting to be seen that day). The Plan's standard for emergency care patients who "walk-in" without an appointment is that they be seen "as soon as the provider's schedule permits."

However, there was no evidence found that the Plan has a mechanism in place to follow-up on complaints involving delays in getting appointments for routine dental services. The Department reviewed Plan grievances regarding problems related to enrollees accessing care in a timely manner. Ten grievances were selected by the Department from the Plan's Category 1 – *"Access to care; emergency and time delays."* The Department found that in three of the 10 Category 1 grievances (or 33%) there was inadequate evidence involving the monitoring and addressing of access issues, and what resulting actions were taken to improve the situation. In addition, five grievances from Category 2 – *"Waiting time at office"* were also reviewed and in this case all five showed the same issue of inadequate follow-up of access issues.

In addition, the Department also reviewed grievances filed at the Plan for the three general practices. There were 26 grievances for one of the practices for the past 24 months and five for the second practice reviewed. No grievances were found for the third practice.

Of the 26 grievances filed regarding the first practice reviewed by the Department (a staff model practice), 11 (or 42%) reported problems related to access. Ten of the 11 (or 91%) related to waiting times in the practice. Despite these numbers of access grievances found, the Plan's access surveys indicate that for this practice the patients are generally seen within 20-30 minutes. This was the case in spite of the fact that the Plan's monthly surveys of the practice did not show a lack of access. The Department's review of the five grievances for the second practice reviewed by the Department found a cross section of issues indirectly related to access yet not a specific pattern to report on.

Corrective Action 3: The Plan shall submit a CAP to demonstrate a documented system for monitoring and evaluating accessibility of care, including a system for addressing and correcting problems that develop, which shall include, but not limited to, waiting time and appointments.

Included should be evidence as to the actions that the Plan will take to effectively address the issues when enrollees complain they have not been afforded timely access to general or specialty dental services and to identify whether these represent systemic problems with access to services that require correction.

Plan's Compliance Effort: The Plan stated that it is implementing an improved multi-tiered system to better monitor and evaluate accessibility of care, which includes a system for addressing and correcting problems that develop. The Plan's provider capacity monitoring system uses only

the most current data, collected on a monthly basis to assure that all information is relevant and conclusions are accurate. This monitoring system is reported by the Plan to be used to identify systemic accessibility problems with providers in the Plan's network. The Plan stated that it is using the following techniques to monitor both individual and systemic accessibility problems to evaluate whether appointment scheduling standards are being met:

Appointment Wait Time Validation: The Plan sends a survey to every provider in the network on a monthly basis to obtain information on appointment availability. The Dental Director validates the information obtained from the monthly providers' surveys by reviewing the appointment logs during the regularly scheduled facility site audits.

Member Surveys: The Plan surveys a randomly selected samples of enrollees assigned to providers' offices. Upon receiving care, enrollees may be asked to complete a survey card and return it to the Plan. The survey instrument includes questions related to the accessibility of care, and specifically the availability of appointments within a three (3) weeks time frame. The results of the surveys are then reviewed by the Dental Director and the Quality Improvement Committee ("QIC"). The Plan uses the results to analyze enrollment capacity and evaluate wait times in provider offices.

Provider Transfer Request Tracking: The Plan also monitors accessibility issues by tracking the enrollee's requests to transfer from their provider. When an enrollee requests a transfer to a different provider, the Plan inquires into the reasons behind the transfer request. Transfers are assigned a reason code, based on the information given by the enrollee. Certain reason codes are indicative of potential access or appointment scheduling problems. A report of these reason codes is forwarded to the Dental Director, the Utilization Review Subcommittee and the Quality Improvement Committee for their review. If review by these bodies substantiates access or appointment scheduling problems, further investigation is then performed and appropriate corrective action is implemented.

Member Grievance / Complaint Tracking: The Plan also monitors the enrollees grievance logs to determine whether there are any enrollee complaints that may result from inadequate provider capacity such as delayed availability of appointments, long office wait times, or other related access problems. If these types of grievances are identified from the log review, then they are referred to Member Grievances and Appeals Subcommittee of the QIC for investigation and corrective action as needed.

Corrective Action: Negative findings resulting from the above activities may trigger further investigation of the provider facility. If an access problem is identified, corrective action must be taken including, but not limited to the following: (1) further education and assistance to the provider, (2) provider counseling, (3) provider probation, (4) suspension of new assignments, (5) transfer of patients to another provider, and (6) contract termination for continuing non compliance. The Plan has an automated system, which generates monthly customized letters to each provider's office with accessibility issues. The letter also requires the provider to adhere to the Plan's corrective action plan regarding the indicated accessibility issues. Depending on the severity of deficiency, the Dental Director re-assesses the effectiveness of corrective actions within 48 hours of implementation to ensure compliance. Investigation results from subcommittees are reported to the Quality Improvement Committee. Accessibility issues are tracked by the QIC along with all other quality-related issues reported by subcommittees.

Trends and other relevant information are included in quarterly and annual reports submitted to the Plan's Board of Directors.

The Plan stated that they are now implementing the corrective action plan outlined above. The Quality Improvement Committee revised and approved these policies on December 19, 2001. The Plan submitted as evidence a redlined version of the revised policies and procedures titled "Accessibility - Monitoring Provider Capacity" *(Procedure #: QIP-001).*

Department's Finding Concerning Plan's Compliance Effort:

Status: Uncorrected

The Plan has taken appropriate steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department's review of the Accessibility-Monitoring Provider Capacity policy and procedure, [identified as "Exhibit C" in the Plan's Response], does indicate that a process and mechanism has been developed for monitoring and evaluating accessibility of care. Included in the policy is a section devoted to addressing accessibility issues with providers along with further corrective action steps to correct the problem(s), and Plan committee involvement.*

However, as stated at the beginning of this section, though the efforts appear to be in place the Plan did not demonstrate the effectiveness of the revised policy and procedure by the date of the Plan's Response. At the time the Department conducts a Follow-up Review of the Plan the Department will make the determination whether the deficiency has been fully corrected, including, but not limited to a review of the Plan's analysis of the effectiveness of the procedure in correcting the deficiency.

UTILIZATION MANAGEMENT

Deficiency 4: **The Plan did not demonstrate a consistent mechanism in place to ensure that the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, treatment authorization requests in a timely manner to meet the requirements of the Act.** [Section 1367.01(a) and (b) and 1367.01(h)(1)(2) and (3)]

Citation: Section 1367.01(a)
A health care service plan and any entity with which it contracts for services which include utilization review functions, that plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, respectively or concurrently with, the provision of health care services to enrollees, or that delegated these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

Citation: Section 1367.01(b)
A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

Citation: Section 1367.01(h)(1)
Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make a determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make the determination, and shall be communicated to the provider in a manner that is consistent with current law.

Citation: Section 1367.01(h)(2)
When the enrollee's condition is such that the enrollee faces imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.

Citation: Section 1367.01(h)(3)
Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the provider within twenty-four (24) hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decisions…

Discussion: The Department found that the Plan has a standard policy of taking no more than five business days for routine referral treatment requests decisions. The decision to approve, modify, or deny the requests is then to be communicated to the provider within 24 hours. If the referral is denied because the treatment is within the scope of practice for a general dentist, the Plan has up to two business days to notify the enrollee.

However, the Department found two cases where the Plan did not provide timely notification of decisions. In both cases it took up to twelve days. Further, the Department found examples where the Plan did not assure adequate continuity of care for individuals being referred for root canal treatment who had received antibiotics as part of their therapy. For such patients, the standard of practice for a tooth to be treated is after the pain and other symptoms of infection, if any, have subsided but when the patient is still on the antibiotic or has just stopped taking it. Antibiotic coverage to control infection for teeth needing root canal treatment is typically seven days. This means the patient would either routinely have to be placed on antibiotics longer than is usual or would complete the antibiotic therapy and be at risk for re-infection. If the antibiotic proves ineffective, the referral should be sooner.

Corrective Action 4: The Plan's shall submit a CAP including, but not limited to, policies and procedures to demonstrate a process by which the Plan will ensure consistent and timely determinations of treatment authorization requests which are consistent with criteria or guidelines and supported by sound clinical principals and processes.

Plan's Compliance Effort: The Plan stated that it does have a mechanism in place to ensure that the Plan prospectively, retrospectively or concurrently reviews and approves, modifies, delays or denies treatment authorization requests in a timely manner to meet the requirements of the Act.

The Plan has a standard policy of taking no more than five business days for routine referral treatment requests decisions. The decision to approve, modify, or deny the requests is then communicated to the provider within 24 hours. If the referral is denied because the treatment is within the scope of practice for a general dentist, the Plan has up to two business days to notify the enrollee.

The Plan stated in their response that it disagrees with the two cases that the Department cited. With regard to the first patient cited in the Preliminary Report, the referring dentist signed the form on April 18, 2001. The Plan did not receive the form until April 26, 2001, as indicated on the form. The Plan stated it is their policy to stamp-date the referral forms upon receiving them. The Plan reports to have approved the referral on April 30, 2001, which was four days later and is in compliance with the Plan's policies and procedures. With regard to the second patient referenced, the Plan stated that the referring dentist signed the form on December 23, 1999. The Plan received the form on January 6, 2001 as indicated on the form. The Plan reported to have approved the referral on January 7, 2001, which is one day later and in compliance with the Plan's policies and procedures.

The Plan submitted as evidence a copy of the Plan's current policies and procedures on Specialist Referrals and Treatment Authorizations, titled "Specialist Referrals and Second Opinions" *(Procedure #: QIP-033).*

Department's Finding Concerning Plan's Compliance Effort:

Status: Corrected

The Plan has corrected the deficiency as requested. However, please note Recommendation and Additional Department Comment below.

Compliance Effort Discussion: *The Department found that the Plan has adequately demonstrated a mechanism in place to ensure that the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, treatment authorization requests in a timely manner to meet the requirements of the Act. The Department reviewed Plan's current policies and procedures on Specialist Referrals and Treatment Authorizations, titled "Specialist Referrals and Second Opinions" [identified as "Exhibit D" in the Plan's Response].*

Recommendation: The Department is recommending that the Plan add an additional sentence in Procedure #: QIP-033. Under the section titled "Timelines", page 5, Process #6 currently it reads in part as follows, "*..Access shall also notify the provider and the member of the anticipated date on which a decision may be rendered."* The Department is recommending that the following be added, "*Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in process (1) or (2), whichever applies.* The Department is recommending this to ensure that the mechanism is in place so that the notification requirements are fully met.

Additional Department Comment: Regarding the two cases cited in the report and the subsequent response from the Plan, though the Department acknowledges that once the referral forms were received it appears the Plan addressed them timely, the Department is concerned about the time lapse in getting the signed referral form from the general dentist. In the first case, it took roughly 7 days for the Plan to receive and in the second case it took roughly 14 days. The

U.S. Mail, (or as in the second case the holiday seasons), may have contributed to the timeliness in Plan receiving them. However, the issue of timeliness needs to be addressed with the Plan's providers. The Plan should consider implementing an additional step whereby the referrals are required to be faxed to the Plan the same day as signed by the provider with the "original" referral to be sent mail and batched with the fax. This would shorten the overall time delay and provide for a more timely response to the request for specialist care.

GRIEVANCE SYSTEM

Deficiency 5: **The Plan's grievance system does not identify, adequately follow-up, and resolve quality of care issues contained within enrollee grievances.** [Section 1368(a)(1) and Section 1370, Rule 1300.68(b)(1) and Rule 1300.70(b)(1)(A) and (B)]

Citation: Section 1368(a)(1)
Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Citation: Rule 1370 as stated above.

Citation: Rule 1300.68(b)(1)
An officer of the plan shall be designated as having primary responsibility for the maintenance of such procedures and for the review of their operations and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the plan's administration whether or not the plan administrates its own grievance system or delegates its authority to resolve grievances to another entity.

Citation: Rule 1300.70(b)(1)
(A) A level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) Quality of care problems are identified and corrected for all provider entities;

Discussion: In its review of the twenty-nine patient grievances filed at the Plan, the Department found two cases concerning interpersonal problems involving a contracted provider and office staff that raised the question of whether this was a systemic problem in the practice. In the first case, a complaint was for both the enrollee and the dental office. The enrollee stated that there was an argument with front-office staff. The practice wanted the enrollee transferred because of the patient's attitude. In the second case, the enrollee called the dentist to complain about the rudeness of the front office staff, which happened to be the wife of the dentist. The enrollee stated that the doctor was rude to her including the repeated use of profanity. These two complaints were filed within three months of each other.

Based on the issues and concerns raised with these two grievances, the Department requested all grievances filed at the Plan for that practice regarding issues related to interpersonal aspects of care. The Plan provided five additional grievances for the Department's review. Of these, four included a complaint related to the interpersonal aspects of care, including alleged rude and confrontational behaviors exhibited by both the provider and the office staff toward enrollees. There was no indication that the Plan had identified a pattern of interpersonal problems within the practice or had taken steps to improve the situation.

Corrective Action 5: The Plan shall submit a CAP that ensures that enrollee grievances involving quality of care issues are followed-up and resolved as highlighted by the Department in

the discussion above. The Plan's corrective action plan shall address the roles of all Plan-designated professionals involved in the process responsible for dental professional review and decision-making.

In addition, the Plan shall submit a CAP that demonstrates that it has instituted grievance procedures to determine and correct systemic interpersonal problems in Plan practices, involving the provider and office staff, which could be detrimental to enrollees receiving necessary care.

Plan's Compliance Effort: The Plan stated in the response that it has enhanced the automation of the enrollee and provider grievance process to ensure an effective system for addressing and resolving complaints and grievances in a timely manner. In addition, the Plan's grievance process is reported to provide a mechanism for identifying systemic or provider trends that may be harmful to patient care.

Grievances can be registered by phone, in writing, or in person. Grievances, which concern quality of care, are forwarded to the Grievances Coordinator for review with the Dental Director.

The grievance information is used by the Quality Improvement Committee ("QIC") to identify trends and potential problems with the Plan's services. If the QIC notes an increase in grievances involving wait time in the provider office, this may indicate an access problem and may be identified for corrective action, such as reviewing the scheduling policies of a particular office or increasing the number of providers in the network. The action recommended by the QIC would be based on analysis of the reasons for the increase in grievances about wait times.

The Plan stated that to ensure grievances receive the proper level of review, they are categorized into one of nine categories. These categories are:

Category	Plan Description
0	Non-complaint
1	Access to care; emergency and time delays
2	Waiting time at office
3	Transportation or shuttle problems
4	Personality problems
a.	*PCD staff*
b.	*Plan staff*
5	PCD office facility problems
6	Communication problems
7	State Denti-Cal problems
8	Quality of Care: substandard care – faulty restorations, ill fitting appliances, etc.
9	Quality of care: inappropriate care – over or under treatment

The Grievances Coordinator assigns the categories and, whenever in doubt assigns category 8 or 9.

The Dental Director reviews a sample category 1 – 7 grievances to ensure the Grievances Coordinator is assigning the correct categories. Grievance information is reported to the QIC on a monthly basis. The monthly report shows the grievances, by category, for each month in the current year, plus the aggregate data for the prior two years.

The Plan stated that "Categories 1 – 7" are reviewed and handled by the Grievances Coordinator, who conducts all research and makes a determination regarding whether corrective action on the part of the Plan or the provider (for enrollee grievances) needs to occur. If the issue is considered a quality issue, it is referred to the Dental Director. The Dental Director also reviews systemic interpersonal problems involving the provider and office staff. The Grievances Coordinator in conjunction with the Dental Director and the Member Grievances and Member Services Subcommittee, ensures that the corrective action is implemented, informs the enrollee of the action taken, and closes the grievance file. The Plan stated that the enrollee is informed in writing regarding the action taken and, if appropriate, the procedures for filing an appeal.

In the event that the provider does not show improvement or is uncooperative with the Plan's improvement efforts in resolving systemic interpersonal problems, the Dental Director will consult with the Quality Improvement Committee ("QIC") to determine the next appropriate corrective action, up to and including termination of the provider's contract. The provider will remain on probation pending the QIC's decision or recommendations. The recommendations may include further investigation through focused review or studies, education to the provider, or disciplinary actions.

Categories 8 and 9, the Plan stated, involve potential quality of care issues and are handled by the Dental Director. The Dental Director conducts the research, including contact with the provider and enrollee, review of the dental chart, and makes a determination regarding whether a quality of care issue is confirmed. The Grievances Coordinator informs the enrollee and the provider in writing regarding the decision of the Dental Director and informs them of their appeal rights. The Dental Director presents all cases involving quality of care issues to the Peer Review Subcommittee. These grievances and outcomes are also reported in writing to the Quality Improvement Committee and the Board of Directors. The Dental Director may schedule an ad hoc meeting of Peer Review subcommittee or present a grievance to a subcommittee at a regularly scheduled meeting, depending on nature and severity of grievance. The Dental Director has authority to place a provider on temporary probation, pending QIC review.

The Plan stated that all complaints involving imminent and serious threat to the enrollee's health will be forwarded to the Dental Director within 24 hours of receipt of expedited review. The Grievances Coordinator will immediately inform the enrollees in writing of their right to notify the Department of Managed Health Care of the grievance.

A letter of acknowledgment of receipt of complaint is sent to enrollee within five (5) days of receipt. Written notice of the complaint will be sent to the provider involved within five (5) working days. Grievances Coordinator or Dental Director is responsible for obtaining necessary information to properly evaluate each complaint or grievance. The Plan stated that it has improved the automation in the Grievances Department for the mailing of the acknowledgment and resolution letters to the enrollees and the provider offices. The Plan has developed specific language for the Plan staff to use for enrollee and provider office letters at the time of

acknowledgment. The Dental Director approves and reviews the resolution letters on different complaint categories to ensure accuracy and clarity of the letter.

The Plan reported that it has implemented the corrective action plan outlined above. The Quality Improvement Committee revised and approved these policies on December 19, 2001. The Plan submitted as evidence a redlined version of the revised policies and procedures, "Complaints and Grievances" *(Procedure #: QIP-006).*

Department's Finding Concerning Plan's Compliance Effort:

Status: Uncorrected

The Plan has taken appropriate steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Plan submitted an updated policy and procedure regarding "Complaints and Grievances" [identified as "Exhibit E" in the Plan's Response]. Although the policy is thorough in many aspects, the Department requests that the Plan address the following items.*

1. *The policy needs to be updated to reflect the Department's current name that is incorrectly referenced in revised Procedure 13, page 3. Also consideration should be given to moving current Procedure 26, page 4, to a second paragraph on Procedure 13. They both appear to relate to Expedited Review of Grievances. Also Procedure 26 reference needs to be changed to reflect the Department of Managed Health Care.*

2. *Regarding Procedure 30, page 5, the Plan states* "Appeals must be submitted to the Plan within 45 days from the date of notification letter to member regarding initial complaint results." *This procedure regarding appeals implies that there is a time limitation that the enrollee has to file an appeal. The Plan can encourage that the enrollee submit an appeal within 45 days but the Plan can not limit the timeframe by referencing "within" 45 days. There is no requirement in the Act limiting the timeframe, as this implies, involving enrollee timeframes to submit appeals. The Plan needs to review their denial letter templates and make necessary adjustments to ensure that this limitation is removed.*

Further Remedial Action: The Department requires that the Plan resubmit the policy, with the corrections highlighted above, within thirty (30) days of the date that the Plan receives the Final Report. In addition, the Plan is to submit a copy of the current denial letter, which will demonstrate that there is not a time limitation requirement on the Plan submitting an appeal.

At the time the Department conducts a Follow-up Review of the Plan the Department will make the determination whether the deficiency has been fully corrected.

VI. ADDITIONAL FINDINGS AND RECOMMENDATIONS

Finding: **The Department found instances where the Plan's response letter to enrollees filing grievances was inappropriate.**

Discussion: During the on-site survey the Department came across several examples of response letters to enrollee grievances filed that contained language which did not seem neither appropriate nor professional in addressing the issues and concerns raised. For example, in Grievance #23, the complaint involved a dentist who had the assistant perform one aspect of the cleaning of the patient's teeth. The Plan's resolution letter appeared to place the responsibility for the apparent misunderstanding and communication problem with who should be doing the teeth cleaning on the mother. The Plan wrote to the patient's mother, "The office was not aware you had any questions about this procedure since you sat in the corner of the room and said nothing to the Dentist."

If the dentist is having an assistant perform some aspect of the treatment, it is reasonable for the provider to bear some of the responsibility for explaining to the patient or the patient's mother what is occurring. This is particularly the case for patients from cultures where it is not considered proper to directly question a person in authority such as a dentist. The letter to patients regarding communication problems should not place the blame on the patient's mother without clear evidence that the patient was at fault.

In Grievance #22, the enrollee wrote that the Plan should provide nitrous oxide free of charge. In the letter to the enrollee, the Plan wrote, "We do not feel it is our responsibility to provide you Nitrous Oxide for your dental treatments."

The Plan should only state what the dental plan covers, or in this case does not. Further, the letter from the Plan pointed out that the enrollee had "failed multiple appointments." This statement was unnecessary since it was unrelated to the complaint.

Recommendation: The Plan should develop specific language for the Plan staff to use in enrollee letters, which is appropriate, clear, concise, and free of unnecessary, and possible confrontational statements that do nothing other than create ill will with the enrollees the Plan is providing care to.

Plan Response to Finding: The Plan concurs with the Department's recommendation and is implementing the suggestions. The Plan stated that it has improved the automation in the Grievances Department for the mailing of the acknowledgment and resolution letters to the enrollees and the provider offices. The Plan has developed specific language for the Plan staff to use for enrollee and provider office letters at the time of acknowledgment. The Dental Director reviews and approves the resolution letters on different complaint categories to ensure accuracy and clarity of the letter.

A P P E N D I X A

General Practice Chart Review Findings

Criteria	Practice #1 *(a contracted practice)*	Practice #2 *(a contracted practice)*	Practice #3 *(a staff model practice)*
Informed Consent* ***Please note that the Department's observation/ comments related to "Informed Consent" are being provided to the Plan as a finding since it is not specifically defined by the Act as a requirement.**	Both **Practice #1** and **Practice #2** used a General Dentistry Informed consent form that does not meet the requirements of proper informed consent. The form includes a consent that gives the dentist permission to make any/all changes and additions in the treatment plan as necessary. Specifically, the section reads as follows: "Changes in Treatment Plan: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary." The process of informed consent requires that the dentist follow the same procedures in obtaining consent for changes in the treatment plan that would be followed when discussing with the patient the original plan of treatment. Having the patient sign a form that gives the dentist broad discretion to alter the treatment plan without obtaining a consent, which is informed, does not meet recognized standards.	Refer to Practice 1 In addition, the medical history forms used in **Practice #2** had the following statement just above where the patient signed the medical history: "I authorize Dr. ___ to administer local anesthetic, drugs or any treatment procedure he may deem necessary." The statement is too broad as described above and its inclusion on the medical history form is inappropriate.	No issues found

A P P E N D I X A

Criteria	Practice #1 *(a contracted practice)*	Practice #2 *(a contracted practice)*	Practice #3 *(a staff model practice)*
X-rays	There were four of 10 cases (or 40%) where deficiencies in x-rays were not identified by the Plan. For Patient #1.1, the Plan identified lack of a sufficient number of x-rays for diagnosis but limited this finding to failure to take a periapical x-ray of a third molar (wisdom tooth). There was also a failure to take other films in accordance with FDA guidelines. These include a tooth with a large area of decay and teeth with existing large restorations. The Plan should identify all areas where there are an insufficient number of x-rays for diagnosis. Again, for patient #1.6, the Plan identified lack of a sufficient number of x-rays for diagnosis but limited this finding to the need for a full mouth x-ray series because of planned periodontal treatment. The necessity of two bitewings per side should have been noted as well since only one bitewing per side resulted in overlap, which compromised the diagnosis of decay in the posterior teeth. Case #1.9 was an instance where anterior periapical films were taken too frequently. In August 1999, two anterior periapicals were taken. The patient was 14 years old and had no decay between the teeth. Six months later three anterior periapical films were taken again showing no decay between the teeth. At the next visit six months later, three anterior and two posterior periapical films were taken. No decay was present between the teeth. Given FDA guidelines, there was no need to take the periapical films at either of the last two visits. Patient #1.10 indicated that full mouth x-rays had been taken one month ago. These films were not obtained and there is no indication in the record that they were requested. The x-rays that were taken were insufficient to diagnose the case. There was overlap on bitewing films, which hampered the diagnosis of decay between the teeth. A filling was done on tooth #5 and the x-ray failed to adequately show both of the surfaces between the teeth.	No Issues found	There were five of 20 cases (or 25%) where deficiencies in x-rays were not detected. For patients #3.7, and 3.12, x-rays were taken too frequently. The baseline x-ray series included six anterior periapical films and these were repeated when the patients were seen on recall. Given the patient's oral condition, FDA guidelines would indicate that these films should not be taken at the recall visit. Patient #3.16 had two periapical films taken of the central incisor region of both arches and these exposures were taken again at three recall visits. There was no apparent reason in the record for taking these particular exposures this frequently. For patient #3.11, the Plan found that there was not a sufficient number of x-rays for diagnosis for periapical films but failed to identify the need for additional bitewing films. Only one bitewing film per side was taken which did not permit the mesial surface of the first premolars and the distal surface of the cuspid to be shown. The Department also found that the quality of the bitewing films was inadequate because of overlap.

A P P E N D I X A

Criteria	**Practice #1** *(a contracted practice)*	**Practice #2** *(a contracted practice)*	**Practice #3** *(a staff model practice)*
Preventive care	In three of 10 cases (or 30%) in **Practice #1**, there were deficiencies in the quality of preventive care that was not identified by the Plan. For patients #1.1, 1.2 and 1.10, no fluoride therapy was recommended for patients with significant decay.	No Issues found	No Issues found
Treatment Planning	There were three of 10 cases (or 30%) in which deficiencies in the sequence of the treatment plan were not identified by the Plan. For patient #1.5, the sequence of care was preventive first, fillings and periodontal care both second, root canal and extractions third and then prosthetics fourth. Generally recognized standards are that needed extractions, root canal, and periodontal care should be done before fillings. Periodontal care and fillings were given the same priority and periodontal treatment (scaling and root planing) and fillings were done on the same side of the mouth on one visit. Periodontal therapy should be completed in advance of restorative care. In case #1.8, both fillings and root canal treatment were given the same priority (2) for care. The patient needed early treatment of tooth #19, which may or may not have needed root canal treatment. Further, there was a large decayed area on an upper molar (#3) which likely required a root canal, and early treatment of this tooth would have reduced the likelihood of an emergency situation arising. After the first appointment, however, the patient received four fillings on teeth with less emergent problems. For patient #1.10, the sequence of treatment did not follow generally accepted guidelines and there was no indication in the record why this was not done. There were several badly decayed teeth needing extraction. Extractions were listed in third priority after preventive and fillings when guidelines indicate they should be done earlier in treatment. Early treatment was indicated for one badly decayed tooth to lessen the likelihood of the need for a root canal treatment, yet a number of teeth with very early decay were treated and this tooth had not been treated at the time of the last visit.	No Issues found	No Issues found

A P P E N D I X B

Orthodontic Practice Chart Review Findings

Practice #4

Deficiencies found by the Department in the care provided which were not found by the Plan.

- The Plan's auditor did not utilize an "identifying" number to designate the patient.
- Soft tissue cancer exam or screening was not found for the ten patients.
- TMJ evaluation was not present for seven of the patients.
- Examination of the dentition was not recorded or merely noted as "WNL" for six patients.
- There was no evidence of a periodontal examination for eight of the patients.
- In one case the Provider did not sign the patient's medical history form.
- The Provider did not witness the Patient's Informed Consent Form by date and signature for the ten patients reviewed.
- Final radiographs and photos were not found for the following patients in Practice #4: Patient #1, whose appliances were removed 07/23/98; Patient #3, whose appliances were removed 07/08/97; Patient #10, whose appliances were removed 12/13/97; Patient #4, whose appliances were removed 06/21/97, Patient #5, whose appliances were removed 07/17/99, Patient #8, whose appliances were removed 04/24/01, and Patient #9, whose appliances were removed 11/22/98.
- Patient #1, whose appliances were removed 07/23/98, was last seen by Practice #4 on 9/08/98, only two months after treatment was completed. Patient #10, whose appliances were removed 12/13/97, was last seen on 10/24/98, ten months after treatment was completed. There was no chart entry for Patient #8 since his appliances were removed on 04/24/01. The question of continuity of care arises when a patient is not seen periodically for a minimum of one year after appliances are removed and retainers placed.

A P P E N D I X B

Practice #5

The Deficiencies found by the Department in the care provided which were not found by the Plan.

- The Plan's Auditor did not utilize an "identifying" number to designate the patients.
  The Patients chief complaint was not recorded for the four cases.
- The Provider did not witness the Patient's Informed Consent Form by date and signature for the four patients reviewed.
- Chart entries were not signed or initialed by the provider for the four patients reviewed.
- Three of the four cases reviewed presented study models that do not meet the "professionally recognized standards of practice". The study models were not diagnostic in that they did not articulate, were not extended to include all of the teeth, and were not extended to demonstrate soft and hard tissue.
- A diagnosis was developed and treatment initiated for the four patients before orthodontic records were obtained. Treatment for Patient #1 was initiated 12/12/96 while orthodontic records were dated 04/03/97. Treatment for Patient #2 was initiated 11/04/97 while orthodontic records were dated 12/03/97. Treatment for Patient #3 was initiated 05/21/98 while the treatment plan was dated 09/28/98. Treatment for Patient #4 was initiated 09/30/97 while orthodontic records were dated 10/09/97.
- Length of active treatment is excessive for this Provider. This may be attributed to a problem of continuity of care, where intervals are too long between appointments. This may also be a problem of quality of care, where diagnosis, treatment planning, and treatment procedures are not adequate.
- Patient #1 initiated treatment 12/12/96 and is still under treatment, a period of four years and nine months. There have been intervals of two months between appointments nine times, three months between appointments two times, and four months between appointments two times.
- Patient #2, a case which requires Orthognathic surgery for correction of the Class III problem, initiated treatment 11/04/97 and is still under treatment, a period of three years and ten months. As yet, Class III surgery has not been performed. Patient #2 had one interval of two months between appointments and one interval of four months between appointments.
- Patient #3 initiated treatment 05/21/98 and is still under treatment, a period of three years and four months. Patient has had one interval of three months between appointments.
- Patient #4 initiated treatment 09/30/97 and had appliances remove 06/05/01, a period of three years and nine months of active treatment. There was one four-month interval when Patient #4 was not seen.

A P P E N D I X C

Accessibility Grievance Analysis

Category 1 - Access to care; emergency and time delays	
Grievance #2	The complaint had two aspects, both dealing with access. The first was that the patient could not get an appointment for four weeks and the second was that the practice called to reschedule the appointment time the night before since the doctor would not be in the office at the scheduled time. The Plan followed up with respect to the rescheduling of the appointment but there was no evidence in the record regarding follow up regarding the wait of four weeks for an appointment, which is in excess of the three week plan standard.
Grievance #4	The complaint was that the practice refused to make an appointment when the enrollee called because "they had not made their schedule for next month yet" and the practice would call her. The enrollee stated that the practice had not called back for three weeks. The follow up by the Plan determined that the practice had made an appointment for the enrollee's child. However, the date of that appointment was for six weeks after the date of the complaint. There was no evidence in the grievance file regarding the reason for this delay or whether access was being delayed because the practice would not make appointments for the next month.
Grievance #5	The complaint was that the patient could not get an appointment for 3 months and the second was a 30 minute wait after arrival without being seen. The Plan followed up with respect to the 30 minute wait in the office but there was no evidence in the record regarding an evaluation of the claim that there was a three month wait for an appointment.
Category 2 - Waiting time at office	
Grievance #13	The enrollee reported an in-office wait time of at least 30 minutes for several appointments and there was no evidence in the record that the Plan had followed up regarding the in-office waiting time or had informed the practice of this aspect of the complaint. For enrollee #11, the complaint was an hour wait after the scheduled appointment time. The patient left without being treated. The practice stated that the reasons were that they were short-staffed and when they had called the patient to be seen, she was outside smoking a cigarette and did not hear her name, so another patient was seated before her. The Plan failed to get an adequate explanation from the practice in that it did not determine how long the patient would have had to wait had she heard her name being called.

A P P E N D I X C

Category 2 - Waiting time at office *(continued)*	
Grievance #14	The complaint for Grievance #14 came via the patient satisfaction survey. The complaint was that the in-office waiting time was 20-30 minutes. This amount of time is within the Plan standard but was viewed as excessive by the enrollee. Enrollee #12 complained of too long a wait in the waiting room. The Plan contacted the practice and found that the enrollee's appointment was for 10:00 AM and that the staff "was planning to call you in at 10:30." Based on the letter to the enrollee, it appeared that the Plan did not find a 30 minute wait to be objectionable.
Grievance #15	The enrollee complained of excessive waiting time in the waiting room, and there was no evidence in the record that the practice had been contacted to determine their view of what happened or that the practice had been informed of the complaint. At the visit following the complaint, the patient record indicates that the patient arrived at 3:40 and that treatment started at 4:19. The time of the appointment was not indicated, but the time from arrival to the start of care was almost 40 minutes.